

SAMA INSIDER

JULY 2020

**Smoking poll
highlights doctors'
crucial role**

**SAMA: Together we
are stronger**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

**SOUTH AFRICAN
MEDICAL ASSOCIATION**



The South African Medical Association Research Ethics Committee SAMAREC

SAMAREC has been a well-established Research Ethics Committee for the past 27 years.

As a registered REC with the National Health Research Ethics Council (NHREC), **SAMAREC** strives to ensure a diverse Committee Membership, while complying with the set amount of members, which includes Medical Practitioners, Legal and Layperson Members, as per the requirements of the NHREC.

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Meetings are held every second Wednesday evening of the month at 17h30.

The workload is shared among clinical and non-clinical members.

***Kindly note that this is not a full time position**

Should you need any more information or be interested in joining the Committee – please contact or forward your CV to the **SAMAREC Secretariat: SAMAREC@samedical.org**



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Diane de Kock
Editor: *SAMA INSIDER*

Thank you

At the time of writing (22 June), the country has been in lockdown for nearly 90 days. We have 97 302 positive cases, 51 608 full recoveries and 1 930 deaths. Well over half of the country's cases (51 441) are in the Western Cape. These are difficult times for everyone, but particularly for our healthcare workers who are at the frontline daily, risking their health and wellbeing for others.

In this issue, we highlight the importance of caring for the vulnerable during a pandemic (page 4), unpack the results of a recent Foundation for a Smoke-Free World survey (page 5) and thank all those SAMA members who have migrated from the Persal to debit order system (page 6).

On page 7, Prof. Zingela addresses the very real mental health impact the outbreak is having in SA in the context of the recently released UN policy brief on mental health. "SA has started on this path ... [but] what is still outstanding is addressing the underinvestment in mental health that has chronically plagued our health system."

Caring for the carers is vital as COVID-19 numbers continue to rise in SA. A recent collaboration between SAMA and others has resulted in the Healthcare Workers Care Network (page 10), a support network that offers all healthcare workers free support, pro bono therapy, resources, training and psychoeducation.

Groote Schuur Hospital's Prof. Meintjes shares his hands-on experience in dealing with the country's worst-affected metropole and province (page 11). "He and his courageous colleagues are at the coalface of the pandemic daily ... risking their wellbeing in service of others and paving the way for the rest of the country."

On page 17, an Austrian nurse shares his experience after contracting COVID-19 from one of his patients. "I thought of how many others are cramped in small spaces, and how difficult it must be for poorer families who live in slums in other parts of the world to even maintain any sort of physical distance."

Thank you, doctors, nurses and all healthcare workers at the frontline. If you feel your experience may be of assistance to colleagues, please email dianed@samedical.org.

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Caring for vulnerable people during a pandemic



Dr Sizeka Maweya, SAMA President

Vulnerability is the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally. It also refers to the inability to withstand the effects of a hostile environment. In our country and the world over, the most vulnerable people are the children, the elderly and women. In SA, these groups of people live in fear daily. They are afraid to sleep in their homes at night, let alone when they are walking in the streets, for fear of being attacked.

The question that arises is: will these people be forgotten during the COVID-19 pandemic, or ignored, or their needs forgotten? The childhood immunisation programmes are still going on. However, there are places in our country where the vaccines have run out, and nobody is paying attention because we are all engrossed in the fight against COVID-19. Departmental budgets are being adjusted to cater for the needs of COVID-19 across the board.

The elderly receive grants to take care of some of their needs; however, their need for protection against COVID-19 is somehow overlooked. We see them queueing at post offices and ATMs to receive the grants. According to the Universal Declaration of Human Rights, and also as enshrined in our own Constitution and related treaties, all humans deserve medical care, necessary social services and security of livelihood in situations out of their control. While the

elderly are fighting for their right to livelihood, are they protected? Where is the possibility of social distancing in the queues to collect grants?

We should look at alternatives for the elderly in receiving social grants. The government has asked employers to allow people over the age of 60 years to work from home. What about those who are not working – have we looked at their needs, when they are exposed while queuing for grants? We should have come up with a plan to assist them to receive the grants in the comfort of their homes. Social distancing may either be physically unfeasible, or else unlikely to be meticulously adhered to, in grant queues. The elderly represent a potential reservoir of infection, who could infect others either at home or in other interactions.

The people who are marginalised at the best of times, the millions experiencing homelessness, struggling with substance use disorder, or incarcerated, must not be left out. In our country, homelessness poses a major challenge. The government tried to establish places of safety for the homeless during the crisis period – one thinks of the Caledonian Stadium in Pretoria. However, many left such places, citing safety concerns, as fighting for essential resources was the order of the day. We have not heard of their whereabouts since then. They are roaming the streets again, leading the lives to which they are accustomed.

Correctional facilities in our country are densely populated, enclosed spaces with a constant flow of human activity. Many of the incarcerated have recently been given parole in order to decongest these facilities. Communities have been reassured that they are not dangerous to society. The question arises as to why they were incarcerated in the first place, rather than serving their sentences as community service. Salisbury-Afshar, Rich and Adashi report that releasing individuals who do not pose an immediate threat to public safety, reducing arrests and delaying sentencing are now regarded as standard practice the world over. Individuals who are being held in jail because of their inability to afford bail, or for minor infractions or violations, should be released, with support to ensure safety and shelter. Those eligible for parole should be released. COVID-19 outbreaks in correctional settings spread

quickly, hence the need to take decisive, if at times unpopular, actions.

According to the Institute of Tropical Medicine, the current COVID-19 outbreak is overwhelming healthcare systems across the globe, requiring an immediate response. In SA, we are not spared, and we must show willingness to respond accordingly. In the process, however, other health services are being compromised, e.g. women's health, elective surgery and maternal and child health, to mention just a few. One lesson learned during the Ebola virus disease outbreak was that the use of health facilities for childbirth and routine antenatal visits declined, while family planning and safe abortion services were also disrupted. In the ongoing COVID-19 pandemic, much remains unknown about the provision and quality of essential services during pregnancy, childbirth and the postnatal period. We need to provide comprehensive reports every month to reassure the public and vulnerable groups concerned about these services.

The most vulnerable people are the children, the elderly and women

We must never forget how one of our own, world-renowned academic Prof. Glenda Grey, was attacked by authorities for trying to focus our attention on the forgotten health services for the vulnerable in the midst of COVID-19. Health professionals must be the advocates of our health systems, and must not shy away from pointing to the forgotten areas while most attention is focused on the pandemic.

In conclusion, it must be noted that responding to infectious disease outbreaks often entails additional physical and psychological stress for healthcare providers. Long working hours, reduced numbers of skilled workers, shortages of personal protective equipment (PPE) and social isolation can lead to burnout among maternal- and newborn-healthcare providers. In the process of fighting the pandemic, we must always keep an eye on and open mind to our vulnerable society.

COVID-19: FSFW's smoking poll highlights doctors' crucial role

SAMA Communications Department

SA doctors have a crucial role to play in reducing combustible tobacco consumption, but future doctors receive inadequate training for playing this part effectively. This is the view of Dr Derek Yach, president of the Foundation for a Smoke-Free World (FSFW). He also notes that the incidence of smoking among doctors requires urgent attention.

"If smoking does not first reduce among doctors, it does not reduce in the general population: the two are linked, and this is a vital message. Importantly, I am unaware of powerful voices in the medical fraternity in SA who are talking about the risks of tobacco use, and the full range of options available for quitting," he says.

Research has shown that prohibition is never successful

Dr Yach's comments follow the publication of results from the FSFW's global COVID-19 State of Smoking Poll, conducted from 4 to 14 April in SA, India, Italy, the UK and the USA.

Among the SA findings is that tobacco users are twice as likely to increase than to decrease nicotine and tobacco usage under lockdown. This, says Dr Yach, lies at the heart of the problem with a complete ban on the sale of tobacco products in the country.

"Prevention is a key factor in reducing the use of tobacco products, but a sudden smoking ban is not the answer. Research has shown that prohibition is never successful; the reality is that people who are dependent will go to extreme lengths to continue using tobacco products. The question then becomes: who will supply this demand?"

According to Dr Yach and the FSFW poll results, SA erred in conflating the need to control the COVID-19 pandemic with the need to control the complex issues of nicotine and alcohol usage. The imposition of a ban on the sale of tobacco products – which only heightens their demand – ultimately increases illicit trade, and anxiety among smokers.

This anxiety is an important element. The FSFW poll indicates that 66% of smokers

use nicotine and tobacco products as a means of coping with stress and anxiety. Dr Yach points out that a less heavy-handed approach to tobacco control would reduce this behaviour, and associated effects on smokers' mental health.

"The link between severe mental health issues and smoking is profound, and people partially get relief through nicotine; it reduces their stress levels. Not dealing with this human factor is, in my opinion, counterproductive. In other countries, tobacco and a full range of reduced-risk nicotine products are still available because leading professionals advised their governments and told them not to conflate controlling the pandemic with controlling nicotine usage," he says.

Instead, governments should adopt an approach that addresses preventative usage of combustible tobacco products, and seeks to educate the public on tobacco alternatives, such as e-cigarettes and nicotine patches.

"Our research found that among 1 500 smokers, two-thirds were using traditional cigarettes. Of these smokers, about a third had increased their smoking, which raises questions about their sources for these cigarettes. Half did seek to quit, but only a tiny fraction will succeed. As I said earlier, without proper intervention from medical professionals, only around 4 - 5% will succeed; going 'cold turkey' is the most ineffective way of dealing with nicotine usage," says Dr Yach.

Dr Yach further notes that government must adhere closely to science-based approaches to helping individuals reduce their tobacco usage.

"Tobacco control in SA from 1994 and for a decade after was exemplary. It was an era when taxes on tobacco products were increased above inflation, and a ban on advertising was introduced – both effective methods to bring down usage. However, policies have drifted, and instead of looking at best practices from, for instance, the UK, policies oppose the use of safer alternatives as a means of quitting," he notes.

Although SA initially implemented ineffective HIV and AIDS public health policies, these were eventually replaced with the world's largest treatment programme – saving



Dr Derek Yach

millions of lives. Policy change, Dr Yach says, can work with tobacco too.

"It's never too late. We can rely on science to get it done. There are some major tobacco manufacturers in SA, and if I was in government I'd bring these players together with the pharmaceutical industry and tell them we want to reduce usage, we don't want combustible cigarettes on the market, but have them manufacture alternatives to help us do it. I would go further and set a date by which combustibles can no longer be sold."

For Dr Yach, government efforts to reduce tobacco use should be developed as part of a long-term strategy, and involvement of the medical community will be key in making this strategy work, and will pay dividends in the form of improved public health.

Dr Yach is a former WHO cabinet director and executive director for non-communicable diseases and mental health. He was previously the chief health officer of the Vitality Group, and executive director of the Vitality Institute. From 1985 to 1995, Dr Yach worked at the SA Medical Research Council. He has authored or coauthored more than 250 peer-reviewed articles on global health, and has served on several advisory boards, including the World Economic Forum. An SA-trained doctor, Dr Yach holds dual SA and US citizenship, and currently resides in Connecticut.

SAMA: Together we are stronger

Dr Vusumuzi Nhlapho, SAMA acting general manager, Dr Akhtar Hussain, interim trade union committee and SAMA board member

In 1996, a trade union purporting to look after the interests of public sector doctors was registered, causing SAMA a number of challenges. At the heart of the challenges faced was the misalignment between SAMA, a non-profit company established in terms of the Companies Act No. 71 of 2008, and the trade union, registered in terms of the Labour Relations Act No. 66 of 1995. As a consequence of the two being separate legal entities, they could not properly function together.

Several attempts, documented extensively elsewhere, were made to assist the achievement of compliance with the stipulations of the Labour Relations Act by the trade union, but without success.

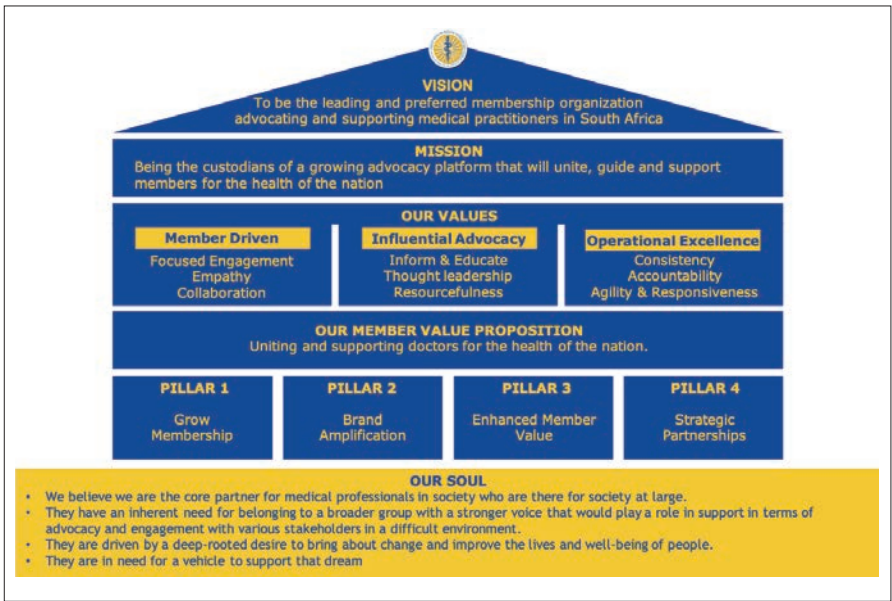
The SAMA Trade Union was placed under administration in October 2019. This was the culmination of a court process required as a result of the legal misalignment mentioned above.

SAMA currently has over 16 000 members. Of the approximately 55% of these who are employed, the overwhelming majority work for the state, and therefore had their SAMA membership fees deducted via the PERSAL system.

The conventional trade union model as envisaged by the law has always been incongruent with the collective life of the medical profession. Doctors, as essential services professionals, cannot ethically embark on strike action. And those who work in management find themselves in the untenable position of being both accounting officer and union member. This poses a threat to the functioning of the profession in its primary duty of being a steward for healthcare before a steward for labour rights.

The court order imposing the current administration process on the union has harsh financial and organisational implications for SAMA's strategy with respect to serving state-employed doctors. Their membership fees were previously deducted as union subscription fees directly from their salaries on the PERSAL system, and the separation of the trade union from SAMA, as well as its subsequent placement into administration, meant these fees were no longer paid to SAMA.

In order to ensure the future of SAMA and to enable uninterrupted membership



for all colleagues, it became imperative that we embarked on the process of migrating subscription payment from the PERSAL system to a debit order.

Taking as its inspiration a quote from surgeon Maxwell Maltz – "Close scrutiny will show that most 'crisis situations' are opportunities to either advance, or stay where you are" – a communications strategy was developed to keep all colleagues informed of the circumstances, and give them the opportunity to ensure their continued membership of SAMA.

Key to the strategy was SAMA's purpose, which is to be the core partner for medical professionals, and to provide a strong voice of advocacy and stakeholder engagement.

Central to this is the need for a single, unified body to speak for medical professionals – even more so now, during the global pandemic. And it will continue to be critical in the weeks and months after the pandemic has passed.

The messaging was transparent and open, and focused on the advantages of being a member of SAMA. The strategy used the hashtag #StrongerTogether to convey its message.

The objective of this communications campaign was to maintain and grow SAMA's strength and its effectiveness as a voice for SA's medical professionals, by persuading at least

half of these professionals to switch to debit orders to pay their SAMA subscription fee.

The primary tactic used, via myriad channels, was direct communication: doctors were reached via SMS, WhatsApp, email and video messages. An unprecedented telephonic calling campaign also took place, using the combined resources of branch secretaries and an independent communications company, to reach as many of our colleagues as possible. In addition, branch Zoom meetings were held to allow for questions and transparent communication about the process.

While the outreach to persuade more of our colleagues to switch their subscription payment method continues, we have been very encouraged by the response so far, which has far exceeded our expectations and has enabled us to beat an optimistic target by nearly 10%.

We thank you all for your understanding that our strength lies in our unity. We remain unwavering in our commitment to professional unity and representation.

SAMA and its members stand together, and will continue to stand together long after the COVID-19 pandemic has eased and passed. Standing together was our initial objective in founding the association 22 years ago, and remains our objective today.

Thank you all for being part of this monumental effort to secure the future of SAMA.

What does the UN policy brief on COVID-19 and mental health mean for SA?

Prof. Zuki Zingela, HOD, Department of Psychiatry and Behavioural Sciences, Walter Sisulu University

On 13 May 2020, 2 months after we reported our first COVID-19 case in SA, the United Nations (UN) released its policy brief on mental health. This came at just the right time, considering the early evidence coming from hard-hit countries on the effects of the outbreak on mental health, and what we are witnessing in the Western Cape. The policy brief is a call for action on mental health in the context of the COVID-19 outbreak.

What does the brief say?

The brief sounds a stark warning on a looming major crisis in mental health, should countries be caught unprepared. The recommendation is that mental health “must be front and centre of every country’s response to and recovery from the COVID-19 pandemic”. What does this mean exactly? Mental health conditions and psychological distress are expected to escalate in societies across the world. Reasons for this are the effect of the outbreak on a nation’s health and health systems, and the effects of isolation due to measures of social distancing, quarantine and physical isolation, to name a few. The fear and anxiety about oneself or one’s family being infected is a given in pandemics that carry a risk of mortality. The economic impact of the hard lockdowns that have had to be employed to address the outbreak have added further strife. Frontline healthcare workers’ mental health is also expected to be negatively affected even as they continue to be at the forefront of country responses to

the pandemic. The brief recommends rapid implementation of the following:

- identifying and increasing support for more vulnerable groups within our population, such as women and children at risk of abuse, older adults, those with pre-existing mental conditions, frontline healthcare workers or people already caught in conflicts or in at-risk situations, e.g. immigrants with no fixed home or settlements.
- finding innovative ways of strengthening existing psychological support and providing mental health interventions
- addressing the longstanding underinvestment in mental health support and services through integrating psychosocial support and interventions in country action plans for the outbreak from inception –mental health should not be treated as an afterthought, but as an integral and essential part of COVID-19 action plans
- applying a holistic approach of promotion, protection and interventions for mental health across the whole of society
- ensuring widespread availability of emergency mental health and psychosocial support
- supporting recovery from COVID-19 by planning and establishing mental health services for society’s future mental health needs –including strengthening or building of community care services, reinforcement of human resource capital to ensure adequate mental healthcare workers across the whole multidisciplinary team.

- ensuring that universal health coverage includes coverage for mental conditions.

How do we turn the brief into action?

What should we do, as a country, to turn the policy brief into tangible benefits that will strengthen our ability to address the anticipated increase in the mental health burden of disease? SA has already started on this path by adopting and implementing collaborative initiatives across private and public partners, and by employing innovative ways of addressing the mental health challenges brought on about by the pandemic. Virtual consultations and interventions are now an accepted choice for both practitioners and the patient. A public-private partnership of a network of health practitioners and providers has already been formed to help support and care for frontline healthcare workers.

What is still outstanding, however, is addressing the underinvestment in mental health that has chronically plagued our health system. As much as the outbreak has brought about unexpected costs incurred because of our response, it also provides us an opportunity to address glaring and longstanding shortcomings in our health systems. If we do not heed the call to fortify our response to the expected upsurge in psychological distress and mental conditions, we risk losing a golden opportunity to redress what has been a longstanding disregard of the nation’s mental health needs.

MPS calls for National Guidelines

SAMA Communications Department

The Medical Protection Society (MPS) is calling for the HPCSA to urgently clarify what guidelines healthcare professionals should follow when making decisions about the withholding and withdrawing of treatment during the COVID-19 pandemic.

This call follows a survey finding that many doctors in SA are fearful of recrimination if put in the difficult position of having to ration patient treatment.

The MPS survey of doctors across SA found that almost one in three respondents (29%) were either concerned or extremely concerned about facing an employer, criminal or HPCSA investigation for making a decision to withhold or withdraw life-prolonging treatment such as ventilation.

Doctors currently have no national guidelines to refer to when making such difficult decisions.

Dr Graham Howarth, head of medical services, Africa, said: “MPS has written to the HPCSA

calling on the body to either study the CCSSA guidance and issue a statement in support of the document, or to issue its own guidance outlining its view as regulator.

“Agreeing national guidelines will be complex, and we do not presume to have all the answers. We do, however, know that such guidelines are needed in order to enable doctors to focus on their patients with less fear of legal recriminations.”

The doctor-patient relationship during COVID-19

Brandon Ferlito, *bioethics researcher, SAMA Knowledge Management, Research and Ethics Department*



The doctor-patient relationship is considered to be a fundamental element in medicine's ethical principles, and has been defined as a consensual relationship in which the patient actively seeks assistance from a doctor, and where the doctor actively recognises the person as a patient.

The relationship between a doctor and a patient is at its core a fiduciary relationship, in which, the doctor, by entering into the relationship, agrees to obtain informed consent, respect the patient's autonomy and maintain confidentiality. The relationship also consists of the doctor explaining treatment options to the patient, providing the highest level of care and undertaking not to end the relationship with the patient without giving him or her sufficient time to find a new doctor. However, such a contractual definition fails to portray the immense and profound nature of the doctor-patient relationship, especially during the COVID-19 pandemic. Several ethical issues may characterise the patient-doctor relationship during the current crisis, particularly those of informed consent and confidentiality.

As discussed below, doctors have legal and ethical obligations to obtain informed consent and to safeguard the confidentiality of the patients under their care, with exceptions under certain conditions.

Informed consent

SA law clearly sets out the conditions that are required of doctors when obtaining informed consent from a patient. Section 12(2) of the Constitution states that: "Everyone has the right to bodily and psychological integrity, which includes the right – (b) to security in and control of their body," while section 7(1) of the National Health Act No. 61 of 2003 (NHA) states: "a health service may not be provided

to a user without the user's informed consent," and section 8(1) further states: "A user has the right to participate in any decision affecting his or her personal health and treatment."

Under normal circumstances, doctors who treat competent patients without their informed consent breach the patient's rights and violate basic standards of medical ethics. However, COVID-19 has raised unique problems and exceptions concerning informed consent. Section 4 of the disaster management regulations states that no person may refuse medical investigation for COVID-19, testing, or quarantine or isolation.

This means that informed consent is not required for testing and treating COVID-19 where this is essential to protect public health. Section 7(1)(d) of the NHA states that it is not required where "failure to treat the user, or group of people which includes the user, will result in a serious risk to public health." However, doctors must still make every effort to obtain the informed consent of the patient.

The SAMA COVID-19 ethics guidelines recommend that doctors do the following:

"If the situation is life-threatening and there is no proxy available, as may be the case during the COVID-19 crisis, and treatment is necessary to delay irreversible damage to the patient's health or to prevent death, the ... NHA allows for treatment to be given without the consent of the patient or the proxy provided that the patient has not previously expressly, impliedly or by conduct refused such treatment."

The guidelines go on to state that doctors must maintain clear records of all the reasons for the actions they take, especially if the patient or the patient's representative does not provide any sort of informed consent, or if there is no time to apply for a court order.

Limiting a patient's autonomy by not obtaining that patient's informed consent can be ethically justified for the strict purpose of advancing the interests of public health.

Confidentiality

Confidentiality is one of the main obligations of medical practice. It requires doctors to keep confidential information about a patient's health private. Section 14(1) of the NHA states: "All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential."

Patients share confidential information with doctors daily. If the confidentiality of this information is not secure, confidence in the doctor-patient relationship risks becoming comprised. However, as with informed consent, confidentiality during the COVID-19 also raises about ethical concerns, as in some situations confidentiality is limited. Section 14(2) of the NHA states that no doctor may disclose any information about a patient, unless:

- "(a) the user consents to that disclosure in writing;
- (b) a court order or any law requires that disclosure; or
- (c) non-disclosure of the information represents a serious threat to public health."

With regard to public health and COVID-19, regulation 11H(5) of the disaster management regulations states that:

"No person may disclose any information contained in the COVID-19 tracing database or any information obtained through this regulation unless authorised to do so and unless the disclosure is necessary for the purpose of addressing, preventing or combating the spread of COVID-19."

As with informed consent, limiting confidentiality for the strict purposes of protecting the health of the public can be ethically justified. COVID-19 is a notifiable disease; consequently, the law imposes mandatory confidentiality limitations with regard to the disease.

Acting cautiously in exceptional circumstances

During the COVID-19 crisis, doctors will be and already are responding under extraordinary circumstances, and adhering to standard ethical practices may not be possible. Nevertheless, this does not mean that doctors should neglect their ethical and legal obligations to patients. Doctors must act prudently and professionally, more so during this time. Doctors should strive in particular to uphold the ethical values of service to humanity, respect for the dignity and autonomy of individuals, promoting equality of all patients, professional competence, honesty and social justice.

References available on request.

Chronic medication repeat script directive: An update

Dr Vusumuzi Nhlapho, *acting general manager, SAMA*



This article serves to create awareness around the chronic medication script directive, and to keep members abreast of the efforts that SAMA has engaged in to get the directive repealed.

On 30 April, the National Department of Health (NDoH) published an intention to exclude schedule 2, schedule 3 and schedule 4 substances from the requirement in section 22A(6)(f) of the Medicines and Related Substances Act No. 101 of 1965 that such substances may be dispensed for no longer than 6 months.

It is provided that schedule 2, schedule 3 and schedule 4 substances may be dispensed for a period not exceeding 12 months from the date of issue of a prescription issued by an authorised prescriber where the date of issue of the prescription is:

- up to 6 months before the date of publication of the notice, in which case additional repeats may be issued for a period not exceeding 6 months, and in accordance with the original prescription, in order to ensure that therapy is not disrupted, if the person dispensing the prescription is satisfied that an authorised prescriber initiated the therapy, with the intention that the therapy be continued, and that the particulars of such sale are recorded in a prescription book or permanent record in terms of regulation 35 of the regulations.

- on or 6 months after the date of publication of the notice.

This effectively means that pharmacies (or other dispensing individuals) can repeat prescriptions for all schedule 2, 3 and 4 medicines for an additional 6 months beyond the original duration of the prescription.

On 3 May, the SAMA Knowledge Management, Research and Ethics Department (KMRED) worked on a guideline document in collaboration with the Unity Forum of Family Practitioners (UFFP). This was submitted to the NDoH following their request for suggestions on how the above could be administered to ensure optimal patient-centred care. The concern is that the above exemption does not recognise the importance of individualised patient care and evaluation.

On 5 May the NDoH responded with a document from the SA Pharmacy Council (SAPC) that provided guidelines for pharmacists, and enquired whether the document addressed the concerns of doctors.

The exemption does not recognise the importance of individualised patient care and evaluation

GPs disagreed with the Pharmacy Council, as the directive allows for chronic medication scripts to be dispensed by a pharmacist for a period of 12 months. The pharmacist would then be liable for patient care, and any illness resulting from a chronic script being filled, without the patient consulting a doctor. The doctors decided to submit a request to the NDoH to repeal the decision, rather than to offer comment on the directive issued by the SAPC.

This letter requesting the repeal was sent to the Deputy Director-General (DDG) of Health on 8 May. On 16 May, a meeting

was held with the DDG, members of the SAPC and members of the UFFP. SAMA board member Dr Norman Mabasa asked that the directive be repealed, as it allows for patients to receive chronic scripts for a period of 12 months without consulting their doctor.

The letter noted that this could result in poorly controlled illnesses – for example, in the case of diabetes, as patients could receive chronic medication for a year without consulting their doctor. This is unacceptable, as an HbA1c and urinary calcium excretion (UCE) test needs to be performed twice a year. It also needs to be taken into consideration that diabetes is a major risk factor for poor COVID-19 outcomes.

Dr Mabasa also brought to the DDG's attention the fact that major pharmacy groups such as Dis-Chem, Clicks and Medipost are advertising their ability to dispense chronic medications for a period of 12 months. The SAPC requested that these adverts be sent to them to investigate the allegations. These were sent to the SAPC and the DDG on 18 May.

On 20 May a letter was sent to the DDG asking for feedback from the meeting of 16 May. The letter also reiterated the request for the directive to be repealed, and asked for feedback by 22 May.

To date no response has been received to this letter.

A consultative meeting with the General Practitioners Private Practice Committee (GPPPC) and Specialist Private Practice Committee (SPPC) was held, as well as with the UFFP. The consensus from these meetings was that legal recourse should be sought, and a request made for repeal.

On 29 May another meeting was held with the NDoH and representatives from the SAPC and the SA Health Products Regulatory Authority. At this meeting, resolution was reached that an amended document would be sent to SAMA for comment. On perusing the document, SAMA was of the opinion that the amendments would not resolve the issue, and the decision was taken to go ahead with the repeal process.

This process has not been implemented as yet. Further details will be communicated as received.

Healthcare Workers Care Network: Caring for the carers

SAMA Communications Department

As COVID-19 numbers continue to rise in SA, our healthcare workers are not only contracting and dying from the virus, but the pandemic is having both a mental and physical impact.

Psychiatrist Dr Antoinette Miric recognised the need for support in March this year, and established Mental Health Care for COVID-19 Carers in Gauteng. Dr Miric and her colleagues were very concerned about the impact of the pandemic on SA healthcare workers' mental health, and wanted to take preventive action.

The initiative has since expanded into the Healthcare Workers Care Network (HWCN), a nationwide healthcare support network that offers all healthcare workers across the public and private sectors free support, *pro bono* therapy, resources, training and psychoeducation. Now a collaboration between SAMA, the SA Society of Anaesthesiologists (SASA), the Critical Care Society of Southern Africa (CCSSA), the South African Society of Psychiatrists (SASOP) and the SA Depression and Anxiety Support Group (SADAG), they are supported by the Psychological Society of SA (PsySSA). The EMGuidance and Vulamobile apps are providing technical and logistical assistance and an innovative digital platform. "We are also offering individual and group

support to healthcare workers and leaders and managers, drawing on our volunteer database," says Dr Miric.

The HWCN already has over 550 volunteer mental health professionals, including psychiatrists, psychologists, GPs, registered counsellors and social workers, who will provide help, intervention and support to all healthcare workers. These include doctors, nurses, community healthcare workers, field workers, hospital or clinic personnel (including hospital laundry staff) and porters.

"Healthcare workers are not used to reaching out for support for themselves. I hope that this pandemic helps them to realise that they need to look after themselves first, physically and emotionally, before they are able to look after others," comments Dr Miric.

Convener of the SA Society of Anaesthesiologists' Wellness in Anaesthesia Support Group, Dr Caroline Lee, said it was critically important at present to be as supportive as possible of health workers. She said they often worked without adequate equipment, and were undervalued.

SAMA acting general manager, Dr Vusumuzi Nhlapho, said they were excited to be part of the network and had been working on similar initiatives for years.

He said that the advent of the COVID-19 crisis had pushed SAMA to fast-track programmes to ensure that health workers did not burn out at a time when they would be needed most.

"A survey led by SADAG was held among doctors, and the consensus that came from that survey was that there is a dire need for mental health services among doctors. We are looking forward to learning and strengthening the partnerships we have," he said.

SADAG's Cassey Chambers said that as the pandemic continued to take its toll in SA, healthcare workers were most likely to be exposed to infection on a daily basis. "We already have a strained healthcare system, and now under the coronavirus we find that healthcare workers are working harder for longer hours in an incredibly stressful and difficult environment."

"They typically work long hours and they have to take care of their own family, with all the challenges of home schooling, fatigue and burnout."

Contact the HWCN 24-hour toll-free helpline on **080 021 2121**, SMS 43003 or visit healthcareworkerscarenetwork.org.za for immediate healthcare worker counselling and support.

SAMA guide: Issuing medical certificates and letters during COVID-19

SAMA Communications Department

The multiple changes in workplace limitations, directives and rules during the COVID-19 epidemic have confused employers, employees and health practitioners alike.

SAMA would like to clarify the responsibilities and duties of member doctors during this time with respect to testing, quarantine conditions and isolation, with a focus on the employed patient and requirements of health and labour law.

Labour guidance published on 29 April 2020 requires that employers identify vulnerable and high-risk employees, and the

current level 3 lockdown regulations (which are under intense scrutiny and debate) also require that employers identify staff with comorbidities and vulnerabilities that qualify them to work from home where possible.

This, along with the publication of guidance by the National Department of Health to clarify the specific conditions that would render an employee vulnerable to severe COVID-19 infection, has resulted in some employees requesting staff and their medical doctors to complete tick-box forms stating the specific conditions from which the employee suffers so that decisions

can be made about the employee's work arrangements.

This presents a challenge to patient confidentiality in many instances.

The SAMA legal and knowledge management, research and ethics teams have put together guidance to assist in completing these requests ethically and in the patients' best interests (<https://www.samedical.org/file/1316>).

We have also added a suggested format for the certificates (<https://www.samedical.org/file/1315>).

Questions? Please share any concerns or questions with us at covid@samedical.org.

Groote Schuur Hospital – sharing early COVID-19 lessons

SAMA Communications Department

COVID-19 patients with diabetes and/or obesity are three times more likely to die than those who are HIV-positive, whether the latter are on antiretroviral drugs or not.

That's the hands-on experience of the country's advance guard of clinicians treating coronavirus patients at Groote Schuur Hospital (GSH), where 180 coronavirus-infected patients were under care at the beginning of June, with numbers expected to double over the next 2 weeks as the Western Cape's two main tertiary hospitals (Tygerberg Hospital is the other) deal with a surge in the country's worst-affected metropole and province. More than 1 500 clinicians and other healthcare workers from across the country listened intently during a webinar in which GSH's medical team leader, Prof. Graeme Meintjes, shared his freshly acquired knowledge on all aspects of COVID-19 patient care, symptoms and comorbidities.

Prof. Meintjes, a health advisor to the Department of Science and Technology and the country's research chair in poverty-related infections, is also deputy head of the Department of Medicine at UCT. The webinar is part of a series hosted by Discovery Health in conjunction with *Medical Brief*, the Desmond Tutu HIV Foundation, SAMA, the SA Private Practitioners Forum and the Unity Forum for Family Practitioners. The session was facilitated by Prof. Linda-Gail Bekker, the deputy director of the Desmond Tutu HIV Centre at the Institute of Infectious Diseases and Molecular Medicine at UCT, and introduced by Dr Maurice Goodman, chief medical officer at Discovery Health.

Prof. Meintjes said that as of 11 June, there were 36 000 people in the Western Cape diagnosed with COVID-19, and 900 deaths [on 22 June, 51 441 cases]. This represents well over half of the country's COVID-19 burden, with tourism, the life-blood of the province's economy, believed responsible for multiple seeding of the virus by overseas visitors. GSH serves four of the heavy-burden subdistricts of the Cape Metropole. There was arguably a sigh of relief in the audience as Prof. Meintjes said HIV-positive patients represented just over a two-fold higher COVID-19 infection risk than those without any other comorbidities –

a relatively low contributor to serious COVID-19 debilitation.

"There's no difference between patients with suppressed viral load and those not on ART. It may be socioeconomic factors. HIV is associated with increased COVID risk, but what we're seeing is probably lower than the cited figure of 2.7 times greater risk. While the obesity data are not available, we can see it's a big contributor, especially when there's accompanying high blood pressure. About half our COVID-19 deaths can be attributed to diabetes, but only 12% to HIV," he revealed.

WC represents well over half the country's COVID-19 burden

He said the first COVID-19 patient was admitted to GSH wards on 18 March, and there had been a gradual increase though March and April, escalating dramatically over the past few weeks.

"The first few weeks gave us an opportunity to prepare psychologically and communications-wise, agree on a plan for the redeployment of staff and to rapidly scale up. We now have isolation rooms and six wards set aside for those under investigation, including the maternity and psych wards," Prof. Meintjes said.

Deaths strongly age-related

About 25% of deaths in the Western Cape were people in their 50s, and another 25% those in their 60s, with the percentages climbing with age.

Serious comorbidities nearly always contributed to the (far lower) mortalities in younger age groups. COVID-19 affected males more severely than females, with the biggest risk factors being uncontrolled diabetes, obesity, cardiovascular disease, hypertension and pulmonary disease. About 5% of all their admissions required ICU treatment.

Asked how common pulmonary emboli were, Prof. Meintjes said about 25% of patients at the severe end of the COVID-19 spectrum

were shown to have them and/or deep vein thrombosis, with an increased mortality risk of 22 - 33%.

He recommended treating patients without intubation, where possible. His team's early experience was that high-flow nasal oxygen (HFNO) had a 31% survival rate, with 55% of serious patients intubated. Of those on failed HFNO who required ventilation, there had been no survivors – all had either died or were still on ventilators.

Answering a question on the duration of HFNO, Prof. Meintjes said the timing varied according to individual patients.

"Some we've been able to consider weaning after 3 days, and some stay on for 2 weeks. For those on HFNO for 10 days or longer, we worry about pneumonia, and so we do radiology and start them on steroids," he added.

Prof. Meintjes strongly promoted "awake proning" (the turning of patients onto their stomachs for 2 hours or longer, if they can tolerate it), where gravity allows blood to settle in the anterior part of the lungs, providing better oxygenation in two-thirds of patients, according to studies. He said oxygen saturation when doing this increased by up to 20%, dramatically increasing a patient's chances of survival. However, he warned against doing this for severely restless or disoriented patients, as they could easily turn onto their backs.

Asked about the use of extracorporeal membrane oxygenation (ECMO), he said this was in the domain of his critical care colleagues; however, it would only be considered in very select patients, especially those with single organ failure (not multiple). ECMO provides temporary support for patients with cardiac or pulmonary failure.

Thanking Prof. Meintjes, Prof. Bekker said he had cut his teeth on the HIV/AIDS epidemic, which probably helped him prepare for the COVID-19 pandemic. He and his courageous colleagues were at the coalface of the pandemic daily, serving at both Khayelitsha and Groote Schuur Hospitals, risking their wellbeing in service of others and paving the way for the rest of the country, still bracing itself for a surge of COVID-19 admissions.

Source: *Discovery Health*.

COVID-19 and workplace laws: Know your rights

Bertha Shabangu, legal advisor, SAMA Employee Relations Department

The year 2020 has, without a shadow of a doubt, been a challenging one, owing to the COVID-19 global pandemic. In SA, the first positive case was announced on 5 March, and President Cyril Ramaphosa declared a National State of Disaster on 15 March 2020. At the time of writing, SA remains under lockdown, much like many other countries across the world.

This pandemic has placed great responsibility on the shoulders of health workers, particularly doctors, and for that I wish to salute all frontline workers who have and continue to sacrifice their lives to protect the health of the nation.

In light of the above, this article seeks to advise and inform medical doctors of their rights as employees during the fight against this pandemic. The article will highlight important workplace statutory provisions.

Regulations in the workplace

Specific regulations have been issued in terms of section 27(2) of the Disaster Management Act No. 57 of 2002, and the COVID-19 directive on health and safety in the workplace was issued by the Department of Employment and Labour (DEL) setting out specific measures that employers are required to take to protect employees in the workplace from COVID-19. Every employer permitted to operate needs to adhere to sector-specific guidelines that apply to their business, in addition to the measures set out in the directive and the regulations. Employers with less than 10 employees are not required to comply with all measures in the directive, and need only comply with a list of those applicable to them, as set out in the regulations and clause 40 of the directive.

The directive provides that every employer is required to undertake a risk assessment, to give effect to the minimum measures required with reference to the specific circumstances in the workplace. If an employer employs more than 500 people, that employer must submit a record of the risk assessment, together with a written policy regarding the protection of employees from COVID-19, to its health and safety committee and the Department of Employment and Labour.

Employer's obligation to report

The directive provides that if an employee has been diagnosed with COVID-19, the employer

must inform the National Department of Health (NDoH) and the DEL, investigate the cause and review the risk assessment to ensure that the necessary controls and personal protective equipment (PPE) are in place. The employer must also give administrative support to any contact tracing measures implemented by the NDoH.

A safe working environment

In an employer-employee relationship, the employee bears the responsibility of providing employment services, while the employer, among other responsibilities, is contractually required to provide a safe working environment. The DEL directive provides that every employer must keep the workplace well ventilated and ensure that filters are cleaned and replaced.

The measures set out in the directive and the regulations are in line with the employer's obligations under section 8 of the Occupational Health and Safety Act No. 85 of 1993 to provide and maintain, as far as reasonably practicable, a working environment that is safe and without risks to the health of employees. They also align with the national strategies and policies put in place to minimise the spread of COVID-19. Each work environment is unique, and the majority of hospitals will require additional measures to prevent the transmission of COVID-19. Over the past few months we have learnt of health workers contracting the virus, meaning that there is a need to apply more stringent precautionary measures in some hospitals. Occupational health and safety laws allow an employee to refuse to perform their work when they have reason to believe that their health or that of other individuals is in jeopardy.

Provision of PPE

The need for medical doctors to assist as essential service workers should be accompanied by the employer's effort to protect them. One such protective measure is to provide adequate PPE, which is equipment worn to minimise exposure to a variety of hazards. It is the employee's right to receive PPE, and not just any PPE, but equipment that is relevant and of adequate quality, for example, an N95 mask. The directive referred to above confirms that should an employer fail to provide the necessary PPE, an employee may refuse to tender his or her services.

COIDA claims

If an employee tests positive for COVID-19 and such infection can be proven to have resulted from the employer's failure to protect the employee and/or provide a safe working environment (in other words, if the infection arose out of and in the course of his or her employment), then the employee can submit a claim in terms of the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993 (COIDA). Occupationally acquired infections may result from single or multiple exposures to confirmed cases of COVID-19, in the workplace or on an official trip to a high-risk country for work purposes.

Payments are subject to COIDA and/or calculations in terms of COIDA for employees who are temporarily unable to perform the work they were employed for as a result of contracting COVID-19, from the date of diagnosis but for no more than 30 days.

Leave during the pandemic

In terms of the Basic Conditions of Employment Act No. 75 of 1997 (BCEA), an employee is entitled to sick leave for the period of illness. This also applies in the case of an employee who has had a positive COVID-19 test, and is therefore in self-quarantine or self-isolation. This, however means that the employer may request the employee to produce a valid medical certificate. If an employee self-isolates without seeing a health professional and does not produce a medical certificate, then the employer can take the days that the employee has taken off as annual leave, or as unpaid leave.

In accordance with section 20(10) of the BCEA, annual leave may be taken at a time agreed between the employer and the employee, or, if there is no agreement, at a time determined by the employer. This means that the employer may request, but not force, the employee to take annual leave in the event where such employee is self-isolating without a positive COVID-19 test.

Conclusion

I hope this article will adequately remind and/or educate employed doctors on their right to be protected by their employer. The employer's obligation to protect is not only relevant during this difficult time of the pandemic, but remains applicable long after the fight is over.

Stay safe and keep putting up a good fight!

Journal club and CPD accreditation guidelines

Lisa Reid, SAMA CPD officer

Specific guidelines relate to journal clubs and CPD accreditation. Journal clubs meet regularly to critically evaluate recent articles in medical academic literature, and are usually organised around a defined subject in basic or applied research.

Aims of a journal club

The aims of a journal club are continuing professional development via review of peer-reviewed journals or articles, keeping up to date with the literature (not older than 5 years) disseminating information on and building up debate about good practice, ensuring that professional practice is evidence-based, and learning and practising critical appraisal skills.

Setting up a journal club

Roles and responsibilities within the club should be clearly defined, and accreditation obtained from SAMA (cpd@samedical.org). Meetings should have a chair or facilitator, and one person should be responsible for co-ordinating

the meetings. Each member should commit to reading the article beforehand, and all members should be encouraged to contribute their views. A training-needs assessment for the group should be carried out, and the format for the meetings should be decided in response to the needs of the members. Training should be provided as needed (e.g. critical appraisal, presentation skills, etc). It is important to create an environment of shared learning, with clear boundaries: start and finish times and the timetable for the year should all be made clear well in advance.

Content of meetings

Meetings can be topic-based (although this involves more work), or the group can look at an article of interest. One person may present and discuss an article or journal, or it can be discussed as a group. If one person is presenting, this can be an opportunity to practise and to receive feedback on presentation skills.

For critical appraisal purposes, choose an article on a topic of interest, and/or a recently published paper (not older than 5 years), and appraise it using a checklist.

In evidence-based journal clubs, start with a real clinical question, search the literature, select and read the most relevant article before the next meeting, appraise it at the next session and then decide whether/how to put it into practice.

A useful tip is to avoid pulling the article to bits during critical appraisal – the point is to objectively weigh its strengths against its weaknesses.

Minutes of the meetings must be sent through every 6 months to your accreditor for auditing purposes. The article or title of the journal issue discussed can also be sent, should minutes not be available.

For further information on CPD accreditation, please contact Lisa Reid 0766446844 or email lisar@samedical.org.

Dr Mosadi Mahoko wins coveted award

SAMA Communications Department

Dr Mosadi Mahoko, a registrar in the Division of Plastic and Reconstructive Surgery at Stellenbosch University, has won the coveted Jack Penn medal for the best result in SA for the 2019 final plastic surgery exams.

She received a letter from the Colleges of Medicine of SA (CMSA) on 8 April informing her of her medal for an excellent achievement in the FC Plast Surg (SA) final examination of the College of Plastic Surgeons. The Jack Penn medal has only been awarded twice since its inception in 1995.

Dr Mahoko is the first black female SA plastic surgeon to qualify from Stellenbosch University and in the Western Cape.

In an interview, Dr Mahoko said the award was “a complete

unexpected surprise. I fell to my knees when I got the email.”

In his letter, the honorary registrar at the CMSA, Prof. Victor Mngomezulu, said it is customary for medals to be presented at an admission ceremony, but due to the COVID-19 pandemic the 2020 CMSA admission ceremonies were cancelled.

Ascribing her success to “hard work and determination”, she said: “If you hunker down, study the work and are passionate about the work you do, you will be successful.”

Her role model was her mother, the late Prof. Sophie Mahoko, former dean of the School of Health Sciences at the University of Venda.

“I learnt so much from my mother, who died in 2014. She had humble beginnings and worked

hard to become an impressive academic. She instilled in me that you must never let adversity get you down.

“I’ve worked hard with the aim of being a good, sensible plastic surgeon to all my patients. This medal has given me the validation to believe I deserve to be in this field,” said Dr Mahoko.

In 2010, Dr Mahoko worked as a medical officer in the trauma unit at Tygerberg Hospital before joining the general surgery department as a registrar. In 2015, she joined the plastic and reconstructive surgery division. She is now in her final year as a registrar, and hopes to do a fellowship in rhinoplasty next.

“I have a passion for reconstructive surgery and particularly for cleft lip and palate surgery. I would like to work on nasal reconstructive



SAMA congratulates Dr Mosadi Mahoko on winning the Jack Penn medal

tion in these children, as they often have severe nasal abnormalities

“I would also like to apply my knowledge of nasal reconstruction in cosmetic surgery,” she said.

Source: African News Agency (ANA).

Meet SAMAREC member, Mark le Roux

Adri van der Walt, SAMAREC officer

The SAMA Research Ethics Committee (SAMAREC) can boast about the versatility of the various roles that their committee members fulfil in their respective fields. One such member is Mark le Roux.

Appointed in 2017 as a lay member, Mark joined the committee with a wide scope of knowledge and experience.

After matriculating from Wolmaransstad High School, he completed his Master's degree in theology *cum laude* at the University of Pretoria (UP) under the supervision of Prof. Yolanda Dreyer, the first female pastor in SA. While working on his thesis, he held two concurrent positions, one as part-time information assistant at various faculty libraries at UP, where he assisted with research papers, and the second as a practice manager for a high-risk cardiovascular and orthopaedic rehabilitation centre at Zuid-



Mark le Roux

Afrikaans Hospital. After completing his thesis, he continued working in the healthcare industry by joining a pathology laboratory for a few years while starting a part-time LLB

degree. Mark later joined a prominent stem cell transplant centre started by a group of haematologists, where he worked as quality manager for their international accreditation programme, before he crossed over to a full-time career in law. He currently works as chief operations officer for a small group of law firms specialising in personal injury claims.

As a lay member of SAMAREC, Mark makes valuable contributions with regard to compliance-related issues and ethical considerations, while being aware of the day-to-day running of medical practices.

A single father of two unsocialised dogs, he enjoys procrastination, visiting international art museums and collecting poetry books by little-known poets.

We trust that Mark will be with SAMAREC for a long time.

New COVID-19 guide for youth launched

SAMA Communications Department

The Smithsonian Science Education Center (SSEC), in collaboration with the WHO and the InterAcademy Partnership (IAP), a partnership of 140 national academies of science, engineering and medicine, has developed "COVID-19! How can I protect myself and others?", a new rapid-response guide for youth aged 8 - 17. The guide, which is based on the UN Sustainable Development Goals, aims to help young people understand the science and social science of COVID-19, as well as help them take actions to keep themselves, their families and communities safe.

Through a set of seven cohesive student-led tasks, participants engage in the activities to answer questions previously defined by their peers. The questions explore the impact of COVID-19 on the world, how to practise hand and respiratory hygiene and physical distancing, and how to research more information about COVID-19. The final task teaches youth how they can take action on the new scientific knowledge they have learned to improve their health and the health of others. Each task is designed to be completed at home.

The guide includes updated research, activities, quotes from scientists and frontline public health officials and physical and emotional safety tips on COVID-19. It also integrates inquiry-based science education with social and emotional learning and civic engagement.

"We are immensely grateful to the WHO, the IAP, our colleagues at the Smithsonian and other senior project advisors and translators for their perspectives and technical support in ensuring that the science is accurate," said Carol O'Donnell, director of the SSEC. "We are also grateful to the Gordon and Betty Moore Foundation for their support during the development of this module. This work represents the power of collaboration and working closely with others across the globe, even during a time of physical distancing."

"Through this project, the SSEC makes science exciting and approachable for children and youth all over the world, and encourages them to learn by doing," said Dr Soumya Swaminathan, chief scientist at the WHO. "With all the myths and misconceptions

out there, it is important for children and youth to understand the nature of this pandemic and what can be done to prevent future pandemics from happening."

"It is so important for children – wherever they are in the world – to develop their

About the SSEC

The Smithsonian Science Education Center (SSEC) is transforming K-12 Education Through Science in collaboration with communities across the globe. The SSEC is nationally and internationally recognised for the quality of its programmes and its impact on K-12 science education.

About the IAP

Under the umbrella of the InterAcademy Partnership (IAP), more than 140 national, regional and global member academies work together to support the vital role of science in seeking evidence-based solutions to the world's most challenging problems.

scientific understanding and rational thinking,” said Prof. Volker ter Meulen, president of IAP. “Only by being able to make rational decisions based on the best science and evidence can any of us adjust our behaviour to keep

ourselves and our families safe from infections such as COVID-19.”

The SSEC will disseminate the information to youth worldwide in collaboration with the WHO, IAP, educators and museum and

research centre networks. The guide is free, will be available to youth in more than 15 languages, particularly African and Asian languages, and can be found at <https://ssec.si.edu/covid-19>.

Tribute to Prof. Anton Carel Stoltz

Prof. Tawana Kupe, *Vice-Chancellor and Principal, University of Pretoria*

The medical profession has lost a great scientist in Prof. Anton Carel Stoltz, a top infectious diseases expert, who passed away recently from complications following surgery.

Prof. Stoltz held the following positions: Gauteng Health/University of Pretoria – principal medical subspecialist and head of the Division of Infectious Diseases in Internal Medicine; Foundation for Professional Development – head of the Infectious Diseases Unit; Medical Research Council – principal medical researcher; and Ndlovu Care Group – principal medical specialist. His passing away is a loss to the health sciences fraternity nationally and globally.

Prof. Stoltz started his career as a biochemist and researcher. In 1983 he completed his Honours degree in biochemistry, with research into the physical properties of IgM molecules. His Master's degree in biochemistry focused on malaria. He then went on to study medicine, and while doing his MMed (internal medicine) he was selected to go to Belgium as a researcher to pioneer a new field in TB, working in the world-class laboratories of Prof. Johan Grooten at Ghent University, and Patrick De Baetselier at the University of Brussels. The function of mycolic acids in the cell wall of *Mycobacterium tuberculosis* was at that stage unknown. He was asked to start a new field in lipid biochemistry, and look at immunological properties of these long-chain fatty acids.

This was the start of a career in which he dedicated himself unconditionally and with single-minded dedication to relieving the burden of infectious diseases. He felt that as a scientist, he could save millions of lives. In 2010 he became head of the Division of Infectious Diseases at the University of Pretoria. He was an internist and infectious diseases subspecialist, with interests in the management of patients with multidrug-resistant and extensively drug-resistant TB co-infected with HIV, and diseases originating from Africa, including severe malaria,



Prof. Anton Stoltz

schistosomiasis and drug-resistant infections in intensive care units. His research interests were in the field of infectious diseases, including resistant TB, using novel nanoparticle medicine, resistant TB transmission/aerobiology and novel prevention of infection, HIV infections and the heart plus HIV and CMV co-infections, malaria pheromones and malaria drug reformulations.

He was the ultimate overachiever – he worked with various intensive care units at the referral academic hospital, and initiated an infection prevention and control unit as well as antibiotic stewardship from several Centers for Disease Control grants. These projects were used as a platform to teach healthcare workers, students and hospital managers the correct management of infectious diseases, and infection control practices. He was also a consultant to the Council for Scientific and Industrial Research and to the University of Pretoria's TB research programmes, focusing on nanoparticle medicine and novel diagnostics in TB. He was involved in a major breakthrough in collaborative research with the University of Leicester in revolutionising the way TB is detected, through the invention and application of a 3D-printed insert added to simple face masks. This new approach has the potential to detect millions of currently missed infections across the world.

SAMA tribute

It is with great sadness that SAMA notes the sudden passing of Prof. Stoltz. “Anton was incredibly passionate about medicine, and about passing on knowledge to others. Throughout his life, he always advocated for best clinical practices and he was, and will remain, a true pioneer in the field of infectious diseases. He was a fine human being, a great teacher and mentor and a valued friend of SAMA. We will miss him dearly,” said SAMA chairperson, Dr Angelique Coetzee

Prof. Stoltz played a leading role in dealing with COVID-19 in SA, and his expertise in infectious diseases informed, and will continue to inform, medical responses to the disease going forward. “Everything I know about COVID, I learned from him. I really miss him, especially his wisdom and the easy way he could explain a difficult concept,” says Dr Coetzee. His passing leaves a deep void in the medical fraternity in SA and the world.

SAMA extends heartfelt condolences to his family, friends, colleagues and students at this difficult time.

From February 2020, this servant-leader led the Steve Biko Academic Hospital's response to the COVID-19 pandemic, despite facing personal setbacks in his own health. Regardless of the pressured situation he was faced with, he was calm, collected and in control, putting colleagues at ease. This talented hero was a gentle soul, and this was illustrated in the way he interacted with colleagues.

Prof. Stoltz had a natural affinity for guiding and mentoring people, and was a bold initiator of projects. The work of this down-to-earth, unassuming scientist will continue all over the world.

Conducting health research during a pandemic

Adri van der Walt, SAMAREC officer

The COVID-19 outbreak has highlighted the issues involved in doing research during a pandemic or an emergency.

The SAMA Research Ethics Committee (SAMAREC) has been engaged in a number of discussions and issues around proposed research, as well as changes to approved protocols, to accommodate COVID-19 patient safety requirements.

Having learned valuable lessons from previous experience during severe acute respiratory syndrome (SARS), H1N1 and the Ebola outbreaks, guidance has been compiled for the conduct of research in an ethical manner during such situations.

The universal ethical guidelines have been summarised by the WHO. The complete summary can be found at <https://apps.who.int/iris/bitstream/handle/10665/331507/WHO-RFH-20.1-eng.pdf>. These WHO standards and guidelines have been distributed by the National Health Research Ethics Council (NHREC), a division of the Department of Health.

It is the NHREC's recommendation that all researchers, ethics committees and relevant sponsors and healthcare providers engaging in biomedical research adhere to these guidelines.

With tension mounting and the general public desperate for a COVID-19 cure/vaccine, it is imperative that research conducted during an epidemic is scrutinised for ethical soundness, while also considering the time restraints that exist during such conditions. The following is a summary of the WHO recommendations on the ethical standards for research during COVID -19. The ethical standards that research must meet during an epidemic are:

- scientific validity
- social value
- collaborative partnership
- reasonable risk-benefit ratio
- fair and voluntary participation
- independent review
- equal moral respect for participants and affected communities.

Not hindering the emergency response effort

A key aspect of a response to a healthcare

emergency such as an epidemic is research. The devastation caused by a pandemic often creates the specific context in which research can be done. However, the execution of the research should never misuse valuable personnel, infrastructure, equipment or any other resource which is required for use in the pandemic response. Logistical planning on physical data collection or intervention is therefore crucial, and needs to be clearly defined beforehand.

Collaborating with partners

Local and international collaboration should be considered, to jointly prioritise the challenges faced. This will help to avoid duplication, and improve the results of the research, e.g. an international study may lead to an increased population size, and hence potential greater validity of the results.

Ensuring community engagement

Besides the physical and mental health challenges a pandemic can cause, socioeconomic factors must also be considered. Ensuring that the community is involved in the decision-making process is one way to assist with the implementation of research. Building a relationship with the community and being transparent is vital.

Conducting ethics review during emergencies

Ethics committees are encouraged to review research involving human participants/patients. During an outbreak or pandemic, there may be a shortage of available experts. It is essential that ethics committees scrutinise research in depth and also, if needed, acquire relevant expert opinions. Expedient reviews are naturally encouraged during a pandemic, but these should not be at the expense of ensuring that the review is carried out in as much detail as in a routine review.

Adapting research methodology

As with all biomedical research, the research conducted must have scientific validity and social value. If these two criteria are not met, it becomes a risk to the participant/patient,

and in essence, unethical. The research methodology may need to be adapted within the context in which the research is conducted. The researcher must ensure that the research question is appropriate and that the methodology to answer the question is attainable.

Selecting participants/patients for inclusion

The basic ethical principles for protection of and prevention of harm to patients/patients must apply. However, this becomes complex when vulnerable populations (e.g. pregnant women or minors) need to be included in the study. The benefit-risk ratio must always be considered, even during a pandemic.

Obtaining informed consent

Obtaining informed consent is vital, while considering that the uncertainty brought on by the pandemic may result in participants/patients desperate for a cure. It is essential that researchers and ethics committees ensure that research activities are scientifically based, and that interventions are reasonably minimised (within the context of the intervention).

Sharing information

Sample sharing consent must be obtained before samples are collected, stored and potentially biobanked. Data sharing during these times may mean that the researcher will have to share information as soon as it is quality controlled for release (e.g. peer reviewed), without waiting for publication in scientific journals. Where interventions are found to be safe and effective, they should be made known and available to local populations as soon as possible.

Conclusion

Although the prospect of doing research and making a difference during a pandemic may be appealing, it is crucial that the planned research is ethically sound. Should you wish to submit for ethics review any plans for research to be done in the private sector, please contact the SAMAREC secretariat at samarec@samedical.org.

“It didn’t kill me, but I came out stronger”

World Health Organization

An Austrian nurse contracted COVID-19 from one of his patients, recovered, and returned to work with much more resolve and compassion.

Eugene, a 32-year-old nurse, left the elderly care home early on 1 April eager to spend time with his wife and 5-month old son at their newly built house just outside of Vienna. But on the way home, he felt something was not right. He began to feel fatigue, his throat scratchy, and that nagging feeling that he could have contracted COVID-19 at his workplace.

“I could only think of two things: if I have it, how to keep from infecting my wife and little boy, and infecting all these other people in the train.” His anxiety sank in more deeply as he began putting the pieces together. “At that time, our care facility did not have enough personal protective equipment (PPE), and there was a lack of disinfectant. My colleagues and I had to create our own masks out of gauze bandages, while more and more patients were testing positive each day.” He knew the risk was high.

“I could not stomach the thought of infecting my wife and son,” he says. Reaching home, he set up a tent in their garden, and slept there to isolate himself. It was not an easy few days, as spring had only started, and the temperature dropped at night. The symptoms set in: dry and rough coughing, a 39° fever, his whole body aching, and chills despite wrapping himself in layers of sheets.

After a visit from the Austrian health services for testing, his diagnosis was confirmed. “I felt chills down my spine – will I die? What will happen to my family? Will I survive this?” he recalls, describing how the symptoms got worse, as if his lungs were being attacked. He could not breathe, his fever fluctuated and he lost his sense of smell and taste.

As the spring temperature kept dropping, he mustered the energy to set up camp inside: he sealed off half the house to keep his family away. At night he slept in the toilet, because it had heated flooring. “I didn’t care. Besides, I already lost my sense of smell. If I slept in the hallway my coughing would wake my son, and I did not want to take the slightest chance of infecting my wife, who took it very hard.”

His head nurse and the Austrian health services advised him to stay at home. As a mild case, and owing to his young age, he could not be accommodated at any hospital. For over a week he treated his cough with expectorant



and his fever with paracetamol, and doubled up on liquids; as a nurse, he was applying to himself the same care he would dedicate to his patients. He made regular trips to the garden to get fresh air and sunlight, a luxury he said he had never realised he had.

“I thought of how many others are cramped in small spaces, and how difficult it must be for poorer families who live in slums in other parts of the world to even maintain any sort of physical distance,” he says. Most importantly, he stayed in contact with friends and talked about sports, and did regular video-chats with his wife and son – who were just in the next room. “So near, yet so far,” he now muses.

He used his isolation to read up on managing the disease, guidance on how not to infect other people, updates on vaccines and drug trials for COVID-19, and inspirational stories of recovery. It was at this time that he started looking at life differently. “When you’re left alone to battle a disease that has no cure yet and that no-one really knows how to handle, not knowing if you will live or die, while thinking of who will take care of your family or whether you will ever get back to work again, you’re in survival mode. If I survive this, I will make it up – to my patients, my colleagues and my family,” he recalls telling himself.

On 23 April he felt the symptoms begin to wane, and 2 days later his official isolation period ended.

Now he is back at work, ready to pick up where he left off. His care facility has also acquired more than enough PPE and disinfectant for the staff and the patients. He comes back ready with a story to tell them, and to reassure his patients that COVID-19 is not necessarily a death sentence, and that only very few die from it. “It did not kill me, and instead it has made me more resolute and compassionate,” he says.

His road to recovery was rough, but he says it’s not as bad as many others he has witnessed at work or read about on the internet.

Now he uses his experience to lift the spirits of his patients, colleagues and some friends who also contracted COVID-19.

COVID-19 may have given him the scare of his life, but it has also made him stronger. Like over a million survivors across the world, Eugene is one with a story to tell, and the heart for it. “When the antibody tests can be proven really effective by the WHO, or governments, or private companies ... I will be one of the first to volunteer to share my antibodies and try to save even just one life,” he smiles.

Now that’s a frontliner.

Missed case of ovarian cancer goes to trial

The Medical Protection Society shares a case report from their files

A 36-year-old woman presented to her GP complaining of a 6-month history of abdominal bloating and urinary frequency. The GP referred her to a gynaecologist, who assessed the patient and requested a pelvic MRI scan. The scan was reviewed by Dr D, a radiologist, who reported that it was within normal limits with no pathology, and that both ovaries were normal.

Over the next few months, the patient continued to experience abdominal pain and bloating.

A few months later, she was referred by her GP to hospital with shortness of breath and right pleuritic chest pain. An X-ray showed bilateral pleural effusions, and a right pleural drain was inserted. A few days later, the patient discharged herself against medical advice, but was seen in the clinic a few days later, where a left pleural drain was inserted.

The case turned on the reporting of the MRI scan

A CT scan of the thorax, abdomen and pelvis showed a bilateral pleural effusion and bilateral enlarged ovaries. The right ovary was reported as 5 cm in size, with a complex appearance, and it was noted that there were multiple enhancing mesenteric/peritoneal nodular deposits. The conclusion was of a suspicious ovarian mass with evidence of peritoneal and omental infiltration.

The cytology from the pleural effusion confirmed the presence of adenocarcinoma cells of gynaecological origin. The patient was diagnosed with stage IV ovarian cancer and given a terminal prognosis.

She brought a claim against the radiologist Dr D, who was a Medical Protection Society (MPS) member, alleging that he had failed to detect features of bilateral ovarian cystadenocarcinoma, which had led to a 7-month delay in diagnosis of her condition. An expert radiologist instructed by the claimant reviewed the MRI scans that had been reported on by Dr D, and considered that there was a lobulated septated cystic mass on the right ovary.

MPS obtained expert evidence from a specialist in gynaecological imaging, who

was supportive of Dr D's interpretation of the MRI scan. The case progressed to a trial.

When giving evidence, the expert radiologist instructed by MPS showed the court a number of slides to assist in its understanding of the clinical situation. The slides showed normal ovaries, abnormal ovaries, and finally, images of the patient's ovaries. The expert explained

what a radiologist would be looking for, and demonstrated that none of those concerning features were present in the images of the patient's ovaries. The trial judge ultimately considered the evidence of the MPS expert to be more convincing. The judge was very sympathetic to the patient and her family; however, he found in favour of the member, and dismissed the patient's case.



Learning points

- The case turned on the reporting of the MRI scan – if the court had accepted there were features of ovarian cystadenocarcinoma present on the initial scan, then it might have been difficult to defend the case.
- The primary function of professional medical experts is to provide the court with an independent opinion on the clinical issues involved in a case, to help the court make a decision on questions falling within that expert's specialist field. An expert must assimilate the facts of the case, consider the questions asked of him or her and formulate an opinion on the clinical issues based on his or her experience and qualifications.
- Where the court is presented with differing expert opinion, it is up to the judge to decide which expert evidence (s)he most agrees with, and this may be influenced by a number of factors.
- In this case, the MPS expert was instructed "blind", without the benefit of the final diagnosis, in contrast to the patient's expert, who was advised of the diagnosis at the time of his instruction.
- In addition, the MPS expert was in clinical practice, and had a great deal of practical experience reporting on MRI scans in a clinical setting. The patient's expert was retired, and had reported on MRIs for research purposes in the last 10 years of his practice.

Border Coastal angel goes above and beyond

Border Coastal branch member Dr Sibongile Mandondo, who was nominated for the SAMA local hero award in 2017, has recently been in the news.

Dr Mandondo was thanked on social media recently by a 28-weeks-pregnant patient who was rushed to Stutterheim Hospital with diarrhoea and bleeding. “An angel came along and introduced herself as Dr Mandondo, saying I am going to do everything to save your baby.” After prescribing steroids in case of premature delivery, “she gave all the necessary medication and I was sent to another hospital in Mdantsane for more tests. I was discharged a week later, and everything seemed fine.”

At 37 weeks the patient’s legs were numb, and she could not walk properly. “I was admitted again in Mdantsane, and there came this angel again. She noticed my baby’s heart rate was abnormal and instructed the nurses to prepare me for theatre immediately. They worked like lightning, even though I was so scared, they gave me hope. I was in theatre for less than 10 minutes, and gave birth to a beautiful baby girl.

Dr Madondo kept her promise – she saved her life twice, and I am grateful for that.”

Dr Sibongile Mandondo is the obstetrician in the Amathole district clinical specialist team (DCST), where she has been working since November 2013. Her role is to work to strengthen obstetric and gynaecological health services at district and community levels, through supportive supervision and clinical governance.

Dr Mandondo has approached her work in the DCST with a strong sense of duty and enthusiasm. She is a dedicated teacher and is committed to training all cadres of staff wherever she is working. She travels extensively throughout the Amathole District, training doctors and nurses, assisting with ward rounds in district hospitals, as well as doing clinical sessions in the East London Hospital complex as a consultant. With her guidance, Amathole’s cervical cancer screening coverage has improved to within the top 10 nationally, while stillbirth rates have also significantly decreased.



Dr Sibongile Mandondo

Dr Mandondo is dedicated to providing integrated and equitable health services to the people of the Eastern Cape. She demonstrates strong leadership within her district and within the province. She has an infectious laugh and optimistic personality, believing that all difficulties can be overcome!

Doctors step up during COVID-19

Two Border Coastal branch members, Dr Craig Parker and Dr Jenny Nash, have stepped up to assist during the COVID-19 pandemic.

Dr Parker was the inspiration behind newly established East London-based campaign group #iCanHelp, who are working hard to help community members during the ongoing COVID-19 pandemic. Campaign organiser Lisa van Wyk said #iCanHelp was first established on March 19 after she came across a Facebook post by Dr Craig Parker looking for donations for a project he was working on with a team of fellow doctors and engineers, titled Umoya. The project aimed to create a prototype for a new kind of breathing apparatus for local hospitals.

“I came across this [Parker’s post] and loved the ingenuity of our local community and the proactive nature of our doctors. I then contacted him to ask him more about the project, and suggested that I put a post on social media platforms to see if we can get a positive response,” van Wyk said.

“A few days later, Dr Parker got hold of me and asked if I would assist him and his team of doctors in setting up a platform to assist with mobilising the greater East London community to assist the medical frontliners to secure sufficient equipment for the potential COVID-19 influx.

“That is how the #iCanHelp campaign started.” Van Wyk said that the main inspiration of the campaign was to help medical workers on the frontlines of the struggle against COVID-19, while also providing a platform for members of the community to get involved.

“We are all in this together, and we will need everyone to get involved and help in some way,” she said.

The community’s response had been amazing. “The privilege of this responsibility has shown me that locals are kind, generous and willing to step up, add value and support each other. From the first call for regulators, 3D printers and pneumatic experts for the Umoya Project, to the army of women sewing masks for our medical staff

as we support the #masks4all campaign, to the donation of non-perishable items for the nurses, security and cleaning staff tea rooms, to the donation of products and services from local businesses to help with personal protective equipment, East London folk have truly stepped up.”

Dr Jenny Nash, who received a Border Coastal Local Hero Award in 2015, is a member of the Dora Nginza Regional Hospital psychology department. She has been collaborating with the Eastern Cape Department of Health to produce one of a series of mini-podcasts, entitled “Self-Care and Social Media during the COVID-19 pandemic”. The short video deals with mental health, and gives some practical recommendations for self-care and the impact of social media. “The pandemic has affected each of us in some way,” says Dr Nash. “It is important to note that too much media of any kind can affect mental health, and studies suggest that specifically, the amount of media exposure is highly significant.”

West Rand assist Cradle of Hope

The Cradle of Hope in Krugersdorp West, like most NGOs, are finding it extremely challenging to keep up with the desperate needs of their community. SAMA West Rand branch have been assisting them during these difficult times.

Cradle of Hope CEO Melodie van Brakel says: "Under normal operating circumstances, our 15 active projects directly impact the lives of more than 1 200 less fortunate adults and children, every single day. Operating costs across these projects total ZAR350 000 per month, with zero government funding."

With the implementation of the government's COVID-19 regulations, the Cradle of Hope had to improvise, fast. The poor community of Krugersdorp West, mostly relying on piece jobs and grants, were now without options. Instead of the 250 - 300 adults and children coming to the 37 Dekker Street gate at lunchtime for two peanut butter and jam sandwiches, there were now around 500 – with queues forming around the block from 11 am, often for people's sole meal of the day. Sandwiches were no longer enough. The Cradle of Hope staff and residents, along with an amazing team of volunteers, started cooking pots and pots of nutritious stews, soups, pap, rice and samp – and every day at lunchtime, a warm, filling cooked meal is served to the hungry souls waiting outside, along with loaves of bread either bought or donated, and any fresh fruit or whole vegetable packs supplied by an army of kind donors.

Food parcels are packed and regularly delivered by staff to the homes of more than 2 000 beneficiaries – to single mothers and their children, the elderly and the disabled, with basic food items, toiletries and baby care items. Truckloads of vegetables, fruit and maize meal are delivered to other projects,



where an additional 500 - 700 people are fed daily. The Cradle of Hope shares their abundance with other charity organisations and feeding schemes in the greater area.

Obviously none of these additional expenses were budgeted for, and fuel bills alone are sky high. But with unrelenting faith and passion, the Cradle of Hope has kept going.

Letters to the Editor

The *Letters to the Editor* page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare, which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

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Please email contributions to: Diane de Kock, dianed@samedical.org.





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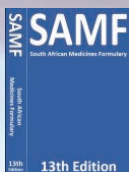


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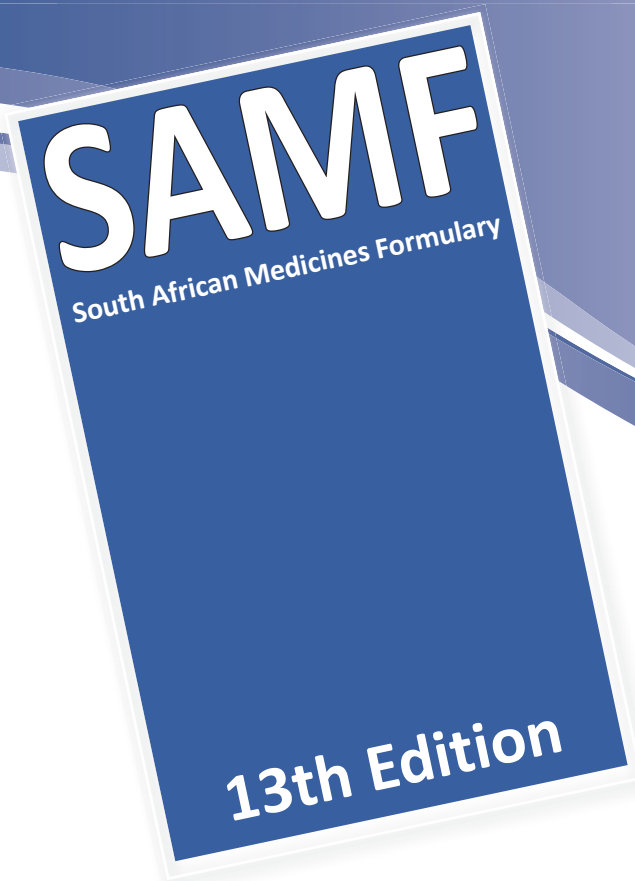
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